STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
(615) 741-5735 or (800) 778-4123 (Toll Free)

APPLICATION FOR LICENSURE AS AN ALCOHOL AND DRUG ABUSE COUNSELOR

UNDERSTANDING THE APPLICATION PROCESS

The requirements for application are supported by the rules governing Licensure of Alcohol and Drug Abuse Counselors, which can be found on the Board's website at: http://share.tn.gov/sos/rules/1200/1200-30/1200-30.htm

1. **All application fees are non-refundable.**

2. You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

3. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Tennessee Board of Alcohol and Drug Abuse Counselors
665 Mainstream Drive
Nashville, TN 37243 (37228 for overnight delivery only)

4. **Allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.

5. If necessary documentation has not been received when your application is received by the Board office, an initial deficiency letter will be sent to you by U.S. postal mail or via email (only if an email address is provided). The supporting documentation requested in the letter or email must be received in the Board office within sixty (60) days from the date of the initial deficiency letter or email notification. **(Files not completed within sixty (60) days will be closed.)**

6. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.

7. **If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.**

8. It is recommended that you do not make arrangements to accept employment as an alcohol and drug abuse in Tennessee until you are granted a license by the Board of Alcohol and Drug Abuse Counselors.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

WRITTEN EXAMINATION

A written exam is required. The exam is offered upon approval by the Board of **all** application documentation. Applicants will be notified of their exam eligibility.

If a candidate does not achieve the minimum score needed to pass the examination, they will be eligible to retake the **next regularly scheduled** written exam, provided the exam will be given during the twelve (12) month time period in which the applicant's application is considered active.

PHILOSOPHY OF TREATMENT OUTLINE

An original three (3) page, single spaced philosophy of treatment paper should be submitted. The outline below is a guideline. Use actual case examples in the paper when appropriate.

1. What is your definition of substance abuse?
2. What is your definition of addiction?
3. How do you see treatment impacting on these problems?
4. What issues are of primary importance in making an initial assessment regarding treatment?
5. What are your treatment goals in working with clients?
6. Describe how you utilize the treatment process, including assessment, treatment planning and goal setting, family involvement, referral systems, aftercare, etc.
7. What factors are important in dealing with the client is ready for terminating treatment?
8. How do you know when a client is ready for terminating treatment?
9. Describe your understanding of confidentiality and client rights as it related to treatment.
10. Describe your view of yourself as a therapist in the treatment process including strengths, weaknesses and any particular orientation to the process (client-centered, behavior modification, 12 steps, etc).

Applications are screened for clerical errors, omissions, and appropriate content and format. The applicant will be contacted by letter for corrections or additions.

APPLICATION CHECKLIST

1. _____ Signed application.

2. _____ The fee submitted with the application includes an application fee of Two Hundred Fifty Dollars ($250.00); the state regulatory fee of Ten Dollars (10.00); and the license fee of Fifty Dollars ($50.00) for a total of Three Hundred Ten Dollars ($310.00). The application and state regulatory fees are non refundable.

3. _____ Complete and submit Jurisprudence Examination per Rule 1200-30-01-.08. The rules and regulations as well as the Tennessee Code can be found at: http://tn.gov/health/article/AD-statutes

4. _____ A certified or notarized copy of birth certificate.

5. _____ All applicants must complete the Declaration of Citizenship form and **have it notarized.** The form can be found at: http://tn.gov/assets/entities/health/attachments/PH-4183.pdf

6. _____ Attach to the application in the space provided a clear, recognizable, passport photograph taken within the last twelve (12) months. The photo is to be signed by the applicant on the back.

7. _____ Submit two (2) recent (dated within the preceding twelve (12) months) original letters of recommendation from mental health professionals, one of which must be a licensed alcohol and drug abuse counselor in good standing, attesting to the applicant's personal character and professional ethics and typed on the signatory's letterhead.

8. _____ **For Level 1:** Submit verification of having completed a minimum of three (3) years clinically supervised, substance abuse counseling experience (6,000 contact hours) during which all eight (8) domains have been performed.

   _____ **For Level 2: Bachelor's degree:** Submit verification of having completed a minimum of two (2) years clinically supervised, substance abuse counseling experience (4,000 contact hours) during which all eight (8) domains have been performed.

   _____ **For Level 2: Master's degree:** Submit verification of having completed a minimum of one (1) year clinically supervised, substance abuse counseling experience (2,000 contact hours) during which all eight (8) domains have been performed.

9. _____ Provide a notarized photocopy of high school diploma or GED. Request transcript from degree granting institution showing highest degree(s) earned and carrying official seal to be sent directly from the educational institution to this office. If the name on the transcript differs from the name on the application, please include the name under which the degree was granted.

10. _____ Out-of-State Verification. Verification from each state where you hold or have held a license as an alcohol and drug abuse counselor or license in any other profession.

11. _____ Complete and submit the application worksheet for at least two hundred seventy (270) contact hours of classroom training.

12. _____ Philosophy of Treatment (original only)

13. _____ Completed Mandatory Practitioner Profile http://tn.gov/assets/entities/health/attachments/PH-3585.pdf

15. _____ **A criminal background check is required.** For instructions on how to obtain a criminal background check go to http://tn.gov/health/topic/CBC-check

8078-001-$300
8078-002-$ 10

Attach
Photo
Here

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARD
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
TENNESSEE BOARD OF ALCOHOL AND DRUG ABUSE COUNSELORS
(615) 741-5735 or (800) 778-4123 (Toll Free)

APPLICATION FOR LICENSURE AS AN ALCOHOL AND DRUG ABUSE COUNSELOR

TYPE OF LICENSE: LEVEL 1 _____ LEVEL 2 _____ RECIPROCITY _____

Name: _____
Last First Middle Maiden (if not used as your middle name)

Current Home Mailing Address:

_____

_____

_____

Current Practice Name & Address:*

_____

_____

_____

***If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.**

Home Phone # (____) _____ Work Phone # (____) _____

E-Mail Address:_____
Do you wish to receive notifications, including renewal notification, from the Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. Yes _____ No _____

Social Security No. _____-_____-_____ Birth Date: _____/_____/_____

Race:_____ Gender: Female _____ Male _____ U.S. Citizen: Yes_____ No_____
All applicants must complete the Declaration of Citizenship form.

Entitled to Live and Work in the U.S. Yes ___ No___

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ____ No _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes ____ No _____

Have you ever been known by any other names besides what is listed above? Yes ____ No _____
If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:

_____

_____

EDUCATION

	Date of Graduation	Major	Degree
High School			
Address			
GED			
Address			
College			
Address			
Graduate			
Address			
Post Graduate			
Address			
Other			
Address			

If additional space is needed, please attach a separate sheet. Include copy of high school diploma or GED. If you have attended college, have the institution send a copy of the transcript directly from the school to the administrative office. The institution submitting the degree must be accredited at the time the degree was granted. The transcript must show that the degree has been conferred and carries the official seal of the institution. If the name on the transcript differs from the name on the application, please include the name under which the degree was granted.

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made.
For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. **"Illegal use of illicit or controlled substances"** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.***

		YES	NO
(1)	Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated because of ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	_____	_____
(2)	Do you currently use any chemical substances with in any way impair of limit your ability practice your profession with reasonable skill and safety?	_____	_____

If so, please list:

_____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

(3) At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances? _____ _____

(4) Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances? _____ _____

(5) Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? _____ _____

(6) Have ever held or applied for a license or certificate to practice professional counseling in any state, country, or province, that had been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? _____ _____

(7) Have you ever held staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action? _____ _____

(8) Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, otherwise disciplined, or voluntarily under threat of investigation or disciplinary action? _____ _____

(9) Have you ever been convicted (including a "nolo contendere" plea or guilty plea) of a felony or a misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?? _____ _____

(10) Have you ever been rejected or censured by a professional association? _____ _____

(11) In relation to the performance of your professional services in any profession:

a. Have you ever had a final judgment rendered <u>against</u> you; _____ _____

b. Have you ever had settlement of any legal action rendered <u>against</u> you; or _____ _____

c. Are there any legal actions pending <u>against</u> you or to which you are a party? _____ _____

(12) Have ever held a license or certificate in any health care profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? _____ _____

(13) My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state.

PRACTICE AND LICENSURE INFORMATION

List below and submit a copy of Clearance From Other State Licensure Boards form to **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED AS AN ALCOHOL AND DRUG ABUSE COUNSELOR.** Additional pages may be added if necessary.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED**. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

SUPERVISORS SUBMITTING EVALUATIONS

Name: _____ Title: _____

Employer: _____

Mailing Address: _____

Dates he/she supervised you: From _____ To _____

Total number of hours worked under supervision: _____

Name: _____ Title: _____

Employer: _____

Mailing Address: _____

Dates he/she supervised you: From _____ To _____

Total number of hours worked under supervision: _____

Name: _____ Title: _____

Employer: _____

Mailing Address: _____

Dates he/she supervised you: From _____ To _____

Total number of hours worked under supervision: _____

WORK EXPERIENCE

Starting with present employment, select only those work experiences which fit the description of qualifying work experience related to the area of alcohol and drug abuse. The final determination of acceptability of work experience will be made by the Licensure Board.

You are responsible for providing any supervisor you have indicated with the Supervisor Evaluation Form and insuring that they return the form.

Begin with your **most recent**, relevant employment and work backward.

Employer _____ **Type of Institution or establishment** _____

Address _____

(Street) (City) (State) (Zip)

Phone # _____ Fax # _____

Position Title _____ Employment Dates _____

Name of Evaluating Supervisor's

Supervisor _____ position/title _____

Does this supervisor meet the qualified supervisor criteria? Yes ❑ No ❑

How many clinically supervised hours (see definition in rules governing Licensure of Alcohol and Drug Abuse Counselors 1200-30-1.10) did you perform in each of the eight (8) domains under this person's supervision? (List total number of hours for each)

_____

_____

_____

Your duties and specialty in the position named above: _____

_____

_____

_____

_____

Employer _____ **Type of Institution or establishment** _____

Address _____

(Street) (City) (State) (Zip)

Phone # _____ Fax # _____

Position Title _____ Employment Dates _____

Name of Evaluating Supervisor's

Supervisor _____ position/title _____

Does this supervisor meet the qualified supervisor criteria? Yes ❑ No ❑

How many clinically supervised hours (see definition in rules governing Licensure of Alcohol and Drug Abuse Counselors 1200-30-1.10) did you perform in each of the eight (8) domains under this person's supervision? (List total number of hours for each)

_____

_____

_____

Your duties and specialty in the position named above: _____

_____

_____

_____

_____

Employer _____ **Type of Institution or establishment** _____

Address _____

(Street) (City) (State) (Zip)

Phone # _____ Fax # _____

Position Title _____ Employment Dates _____

Name of Evaluating Supervisor's

Supervisor _____ position/title _____

Does this supervisor meet the qualified supervisor criteria? Yes ❑ No ❑

How many clinically supervised hours (see definition in rules governing Licensure of Alcohol and Drug Abuse Counselors 1200-30-1.10) did you perform in each of the eight (8) domains under this person's supervision? (List total number of hours for each)

_____

_____

_____

Your duties and specialty in the position named above: _____

_____

_____

_____

_____

EIGHT DOMAIN HOURS

Please carefully document two hundred seventy (270) total hours of alcohol and drug education on this form, including six (6) hours of education in alcohol and drug ethics.

Training Event (Course/Workshop/In-Service)and Date	SCREENING	INTAKE	ORIENTATION	ASSESSMENT	TREAMENT PLANNING	COUNSELING	CASE MANAGEMENT	CRISIS INTERVENTION	CLIENT EDUCATION	REFFERAL	REPORT/RECORD KEEPING	CONSULTATION	ETIHICS	ELECTIVE EDUCATION	**Total Hours A&D Specific**	**Total Work-shop or course Hours**
SUB-TOTAL PER FUNCTION																
CUMULATIVE TOTAL PER FUNCTION																

Attach training event verification of attendance in the order in which they are listed on this form.

AFFIDAVIT AND RELEASE

I, _____ of_____ being duly sworn and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as an alcohol and drug abuse counselor in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as an alcohol and drug abuse counselor.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

_____ _____

SIGNATURE **DATE**

SUPERVISOR EVALUATION

Applicant's Name _____

Supervisor _____ Title _____

Mailing Address _____
(Street or Post Office Box)

_____
(City) (State) (Zip)

Email Address:_____

Supervisor's Degrees/Certifications/Licensees: _____

Work Telephone (___) _____ Fax Number (_____) _____

Program/Agency where you supervised applicant: _____

_____

What was the job title of applicant during the time of your supervision: _____

_____

Acceptable activities that can be credited toward the required alcohol and drug counseling hours are only those activities which are directly related to the eight (8) domains.

Dates of supervision: From _____ To _____

How many HOURS of alcohol and drug counseling did the applicant deliver under your clinical supervision: ____
_____

How many cases (average per week) does this present: _____

What non-alcohol and drug related counseling services did the applicant deliver under your supervision: _____
_____

How many cases (average per week) does this present: _____

How many hours of **direct** clinical supervision did/do you provide to the applicant each week (average) _____
_____.

What activities did/does your clinical supervision include:
❑ sign off on charts
❑ discuss individual cases briefly
❑ discuss individual cases in depth
❑ member of treatment team
❑ other (describe) _____

A. The following items are representative of the skills needed by an alcohol and drug abuse counselor. Please evaluate the applicant only as you have direct knowledge of their demonstrated ability in each area. Mark the rating most nearly descriptive of the counselor's demonstrated skills.

NOT ACCEPTABLE	AVERAGE	ABOVE AVERAGE	
			1. **SCREENING** Demonstrated ability to determine treatment appropriateness and client eligibility for a particular program. Ability to use appropriate diagnostic criteria in determining eligibility and ability to suggest alternative services if necessary.
			2. **INTAKE** Demonstrated ability to perform the administrative and initial assessment procedures for admission to a program. Understands clearly the purpose of the process.
			3. **ORIENTATION** Demonstrated ability to describe to client and significant others program philosophy, program, goals, procedures and rules governing client rights, and treatment costs.
			4. **ASSESSMENT** Demonstrated ability to identify and evaluate an individual's strengths, weakness, problems and needs for the development of the treatment plan.
			5. **TREATMENT PLANNING** Demonstrated ability to work with client to identify and rank problems needing resolution, establish agreed upon goals, and to determine appropriate process and resources to be utilized.
			6. **COUNSELING** Demonstrated ability to utilize special skills to assist individuals, families or groups in achieving objectives through; exploration of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions; and decision making.
			7. **CASE MANAGEMENT** Demonstrated ability to utilize activities which bring services, agencies, resources or people together within a planned framework of action toward the achievement of established client goals. Ability to coordinate multiple service plans.
			8. **CRISIS INTERVENTION** Demonstrated ability to identify a crisis when it surfaces, attempt to mitigate or resolve the immediate problem while using the negative events to enhance the treatment efforts.

NOT ACCEPTABLE	AVERAGE	ABOVE AVERAGE	
			9. **CLIENT INTERVENTION** Demonstrated ability to provide information to individuals and groups concerning available alcohol and drug abuse services and resources.
			10. **REFERRAL** Demonstrated ability to identify the needs of the client that cannot be met by the counselor and/or agency and assisting client in utilizing available support systems and community resources. Ability to utilize other resources while maintaining appropriate client confidentiality.
			11. **REPORT AND RECORDKEEPING** Demonstrated ability to perform the function of documentation to assist the client's progress toward achievement of established goals; facilitate communication between co-workers and other service providers; assist supervisor in evaluating therapeutic skills and effectiveness.
			12. **CONSULTATION WITH OTHER PROFESSIONALS** Demonstrated ability to relate with other professionals (both alcohol and drug counselors and non-alcohol and drug professionals) to assure quality care for the client.
			13. **COMMUNICATION WITH UNDER-SERVED POPULATIONS** Demonstrated ability to recognize and to respond effectively to behavior, attitudes, and values unique to different ethnic, racial, religious groups, homosexual adolescents, women, elderly, and other identified underserved client groups.
			14. **SKILLS ENGAGING FAMILY MEMBERS/SIGNIFICANT OTHERS** Demonstrated ability to involve family members and other significant persons present in client's life into the treatment process. Ability to communicate effectively information about family systems and recovery.

B. Please evaluate the applicant as you observe him/her in the following areas of interpersonal relationship with clients:

NOT ACCEPTABLE	AVERAGE	ABOVE AVERAGE	SUPERIOR	
				1. Respect for client
				2. Care and concern for client
				3. Genuineness with client
				4. Empathy with client
				5. Flexibility with client
				6. Judgment with client
				7. Spontaneity with client
				8. Capacity for appropriate confrontation with client
				9. Capacity for appropriate self-disclosure
				10. Sense of immediacy
				11. Concreteness

C. Listed below are ten (10) basic grounds on which licensure may be refused or revoked. Please read carefully. To your knowledge, has the applicant been involved in any of the following:

(1) Making false statements or representation, being guilty of fraud or deceit in obtaining licensure or licensure renewal, or being guilty of fraud or deceit in the practice of alcohol or drug abuse counseling. Yes ❑ No ❑

Comment: _____

_____

(2) The inability to perform or the consistent unsatisfactory performance of the expected functions of a licensed alcohol and drug abuse counselor. Yes ❑ No ❑

Comment: _____

_____

(3) Knowingly assisting another in the procurement of licensure or licensure renewal through false statements or misrepresentation. Yes ❑ No ❑

Comment: _____

_____

(4) Misrepresentation of professional qualifications, certifications, accreditation, affiliation or employment experiences. Yes ❑ No ❑

Comment: _____

_____

(5) Violations of the provisions of applicable rules or any lawful order of the Board.
Yes ❑ No ❑

Comment: _____

_____

(6) Engaging in malpractice, negligence, incompetence or conduct not authorized in the course and scope of practice. Yes ❑ No ❑

Comment: _____

_____

(7) Violations of standards of patient-confidentiality, as prescribed by the laws of the State of Tennessee, the United States, or the Tennessee Department of Health.
Yes ❑ No ❑

Comment: _____

_____

(8) Conviction of a felony or conviction of any crime involving moral turpitude.
Yes ❑ No ❑

Comment: _____

_____

(9) Any other breach of professional ethics. Yes ❑ No ❑

Comment: _____

_____

❑ I do

recommend the applicant for licensure as an alcohol and drug abuse counselor.

❑ I do not

I hereby certify that all of the information given herein is true and complete to the best of my knowledge and belief.

_____
Signature

_____
Date

This form must be returned to:

Board of Alcohol and Drug Abuse Counselors
665 Mainstream Drive
Nashville, TN 37243

AFFIDAVIT OF SUPERVISOR QUALIFICATIONS

1. I, _____, have provided supervision of the activities

   of _____ pertaining to alcohol and drug abuse counseling.

2. I understand and that, according to paragraph 1200-30-01-.10 of the rules governing Licensed Alcohol and Drug Abuse Counselors, the required qualifications for the applicant's **supervisor** are:

   (a) Has been a licensed/certified alcohol and drug abuse counselor for at least five (5) years; **and**

   (b) Has at least two (2) years experience supervising alcohol and drug abuse counselors; or

   (c) Has received at least thirty-six (36) contact (clock) hours of supervision (by an approved supervisor) of his supervisory work by at least one (1) person doing alcohol and drug abuse counseling.

3. I understand that supervision provided the applicant's parents, spouse (or former spouse), aunts, uncles, grandparents, grandchildren, stepchildren, employees, former counselor, or anyone sharing the same household, shall not be acceptable toward fulfillment of licensure requirements. For the purposes of this rule, a supervisor shall not be considered an employee of the applicant, if the only compensation received by the supervisor consists of payment of actual supervisor hours.

4. I understand that qualifying supervision of my work received prior to the implementation date of the rules will be acceptable as qualified supervision.

5. I certify that I meet **all** the requirements as listed above and am licensed in good standing.

6. My license number is _____ and the date my initial licensure was _____

_____
Signature of Supervisor

ALCOHOL AND DRUG ABUSE COUNSELOR
PROFESSIONAL REFERENCE

Applicant _____

Reference's Name _____ Title _____

Address _____

City, State, Zip _____

Work phone (_____) _____

Relationship to Applicant _____ Length of time of acquaintance _____

Are you a Tennessee licensed Alcohol and Drug Abuse Counselor? Yes ❑ No ❑

The above applicant is applying for licensure as an alcohol and drug abuse counselor. It is our request that you provide information to the Licensure Board regarding the applicant and their relationship with you and others. In addressing interpersonal relationships, it is the belief that these traits impact client care. Your evaluation is of utmost importance in this licensure process.

Please evaluate the applicant as you observe him/her in the following areas of interpersonal relationships with yourself and/or others.

NOT ACCEPTABLE	AVERAGE	ABOVE AVERAGE	SUPERIOR	
				1. Respect for client
				2. Care and concern for client
				3. Genuineness with client
				4. Empathy with client
				5. Flexibility with client
				6. Judgment with client
				7. Spontaneity with client
				8. Capacity for appropriate confrontation with client
				9. Capacity for appropriate self-disclosure
				10. Sense of immediacy
				11. Concreteness

Please complete the following statements:

The applicant may be an asset to the field of alcohol and drug abuse counseling because he/she is:

_____

_____

The applicant may be a liability to the field of alcohol and drug abuse counseling because he/she is:

_____

_____

General Comments: _____

_____

_____

❑ I do
recommend the applicant for licensure as an alcohol and drug abuse counselor.
❑ I do not

I hereby certify that all of the information given herein is true and complete to the best of my knowledge and belief.

_____ _____
Signature Date

This form, along with a letter of formal recommendation on your letterhead, must be sent directly to:

BOARD OF ALCOHOL AND DRUG ABUSE COUNSELORS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243